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Preface

This is a story book; stories that are based on facts; stories about some of the changes that occurred in Hong Kong before and after the sovereignty transfer in 1997 that I myself had been involved in, and taken an active and leading role.

I write this book to remind myself of what a bumpy ride it had been and as an apology to my wife, my children and my friends for my neglect of them because of my devotion to public service.

Writing this book is easy – it only took me a few months of scrambling amid my many commitments. Getting it published is a challenge. I am grateful to my secretary Ms. Louisa Fu for deciphering my unreadable handwriting. I am grateful to Mr. Perry Lam for his excellent advice and succinct editing. I am also thankful to my former political assistant Ms. Kathy Chan for always being there to help when my memory failed me. Above all, I am in debt of the Commercial Press which gives me the greatest support by offering to publish the book.

C.H. Leong
2018

Prologue

The paternal influence

My father Dr. Leong Kam-leng (梁金齡) came to Hong Kong to study medicine from Singapore and graduated with a Bachelor of Medicine/Bachelor of Surgery (MBBS) from the University of Hong Kong in 1938. It was in the following year that I was born. Hong Kong, not the Lion City, thus became the place where my roots were planted.

University of Hong Kong

FACULTY OF MEDICINE

CERTIFICATE ISSUED FOR PURPOSES OF MEDICAL REGISTRATION

This is to Certify that

LEONG KAM LENG

1. Passed the final examination for the M. B., B. S. Degree of this University in December, 1938.
2. That he is of good moral character.
3. That this photograph is sure proof of his identity.

Dean

All the necessary fees have been paid.

Registrar.

Date 17th December 1938

A proud graduate of HKU

Graduating medical students then were posted to different settings. As my father was not exactly a bright student, he was "exiled" to Aberdeen, then a poor fishing village where he was not just the only doctor, but probably the only person who could speak and understand English.

Then the Second World War broke out, and we left for Guangzhou to flee the Japanese occupation. I can still hazily remember that we led a reasonably well-off existence – my father was in charge of the hospital of Guangdong Province (廣東省立醫院). We travelled in private rickshaws most of the time. As far as I can remember, the hospital acquired an ambulance that for some reasons never worked. What I vividly remember is that almost every night we had to take shelter in the hospital avoiding air raids, and the devastation left behind by the bombs that fell elsewhere while the hospital was spared.

After the war ended, we returned to a dilapidated Hong Kong. By then there were seven of us taking up residence in a shared flat in Hak Po Street in Mong Kok in a room separating from our "neighbours" by panels that hardly extended to the roof.

But our lucky star was shining. My father was welcomed back to practise in Aberdeen. As the only doctor and the only person who spoke English, he also became the interpreter for Government officials and the local fisher folks.

He opened a clinic in Wu Nam Street. Medical practice then was spartan to say the least. My parents had to carry the daily provisions of medicine in rattan baskets everyday as they travelled

Serving a bridge between the Government and local people

to Aberdeen by bus remodelled from trucks which, at that time, was the only means of transport to and from Aberdeen.

His practice was comprehensive – from treating cough and cold, to infected fingers from fish hook puncture, to delivering babies.

He was thus a doctor-at-large. Everyone in Aberdeen knew him, for whenever they were sick, there was no one else to turn to as Aberdeen then was an isolated part of Hong Kong.

What sort of doctor my father was came through most clearly in an incident that took place under tempestuous weather. Typhoon signal no. 8 was hoisted and there was a fisherwoman in labour on a junk at the Aberdeen harbour. Without thinking twice, my father and my mother, a nurse, went out on a sampan and in the middle of a rough sea, delivered a five pound baby, a first born, to the delight of his grandparents and parents. A son,

a first born, and therefore a jewel in the eye. And the reward – the fresh catch of the day, a catty of shrimps and subsequently a couple of specially prepared salted fish.

There was nothing my father took more seriously than his duties as a doctor. It was the first day of the Lunar New Year and he was called to certify an elderly fisherman who died on a fishing junk. Without hesitation and undeterred by the superstition that associated it with bad luck, he jumped onto a sampan and performed the necessary ritual. He never asked for a fee, but was rewarded with a red packet of 10 dollars.

My father was mesmerized by the community and, in return, he was considered an "honourary Tanka person" (蜑家佬).

Together with my sisters and brothers, I spent most of the weekends when we didn't have to go to school in his clinic in Wu Nam Street, which was about the only "quality time" we had to be with our parents. Not much parental care was given to us for both my parents had to work hard to deal with their heavy workload. Yet they were most caring and they taught us by example. In this aspect, we were no different from many other children then. For most big families living from hand to mouth, the parents had to work very hard to provide for their children. Those were the days of simplicity when people still believed in "the Lion Rock spirit" and the virtues of hard work.

My father subsequently opened another clinic at 74 Queen's Road in Central. It was under such circumstance that I gradually realized what taking up the medical profession is all about –

A family portrait. My father is fourth from the right

My father's clinic at the junction of Pottinger Street and 74 Queen's Road Central (See signboard in the top-left corner) (Courtesy of Mr. Luk Hon-yat)

commitment, caring, patients first and their recovery taking precedence over everything else. My parents were therefore my role models and they taught and inspired me to take up medicine as my career.

Chapter 1
Against all odds

Surgery is a challenging specialty. It is also a demanding specialty. Physically-demanding, as the surgical procedures could be tedious. Mentally-demanding, for oftentimes the surgeon has to make quick and consequential decisions. If you do nothing, the patient will die; if you do something, he might have a chance. Yes, it is a matter of life and death. You weigh all the pros and cons, then you make a decision and you never regret. It toughens you and your character. You "get on with it" and you don't "dilly-dally".

Life as a trainee surgeon then was by no means easy. There were no "standard working hours" and nobody talked about "work-life balance". You were off duty only when all the work had been done, with no patients' complaints to deal with. As one of the two doctors in the entire surgical department treating 200 patients (the other being Dr. A.E.J. van Langenberg) , I barely had time to leave for a haircut.

Ward round started at 8am, and was over by 10am. Thereafter the professor usually left for boating pleasure at the then Royal Hong Kong Yacht Club, and senior doctors took off for surgery in private hospitals. The two of us were left to take charge of all the

patients and emergency admissions.

On the days designated for operations, one of us had to assist the professor and senior surgeons to perform surgeries. The other one had to do all the preparations for the patients scheduled for surgery: setting up blood lines, checking their status, etc.

Yet I never uttered a single word of complaint, nor did anybody else. For me, surgery is a calling, not a job. Surgery may be a science, but its practice is an art: an art in making decisions, an art in communicating with patients; an art in instilling confidence in the patients and their families; and finally an art in following surgical procedures.

Since it is an art, exposure and experience matter – the more you see, the more you learn, and "practice makes perfect". As my former chief of surgery once said to his blue-eyed trainee who boasted he could remove a patient's stomach in 45 minutes, "If I train a monkey long enough, it will be just as good."

Indeed, a good surgeon is not only a doer. He must also be a thinker and an innovator. Standard surgical techniques are well tried and time-honoured, and can be relied upon to give evidence-based good results. Yet treatments must be adapted to the passage of time, the needs of the patients and cultural differences. Surgeons must keep an open mind about innovations that put patients on the fast track to normal lives.

Treatment of cancer of the bladder, presenting with blood in the urine, is a case in point. In days gone by, the symptoms were usually interpreted as little more than a simple infection of

the urinary tract that called for prescription of antibiotic. The seriousness of the condition was thus overlooked. The recurrence of these symptoms, however, meant the cancer had reached an advanced stage and the only solution was to remove the bladder altogether.

Unfortunately, that would also mean that the patient would be deprived of a receptacle to hold his urine which could only be drained through a hole in the lower part of his body. With his clothing occasionally soiled by urine, the patient gave off a weird odour. This, in the 60's and 70's was something to be frowned upon. The social stigmatization was so strong that the patient would rather suffer the consequence of an advancing bladder cancer and ultimately succumb, than the humiliation of being a social outcast.

Can we reconstruct a bladder using another hollow organ? A segment of large bowel had been tried to less than desirable effect – the contraction was poor, producing a weak urinary stream; the large bowel produced a lot of mucus, often clotting the urinary flow; the large bowel absorbed acid from the urine producing acidosis in the long term. What about a segment of the stomach?

The idea was thus conceived!

Was it technical feasible? The stomach has a thick muscle wall so it should also have a strong contraction. But which part of the stomach could be used? The upper part (body) produced a lot of acid and it may cause irritation or even excoriation of the urethra. The lower part (antrum) might work.

While there were then no ethics committees in hospitals in the late 60's and early 70's, it would still be inconceivable to use patients as "guinea pigs". Evidence base must be established – and I resorted to do a trial using dogs.

Dog lovers and animal rights advocates can rest easy. Every dog used in the trial was properly anaesthetized and had received proper surgical procedures. The laboratory I used, however, was spartan. There was only one technician in the daytime. Oftentimes, I had to return to the dog laboratory at night after social functions I had to attend, often in formal attire, to give post-operative care to my "precious" dogs – clysis and fluid replacement; introducing catheters to drain the "reconstructed" bladder, etc.

All the hard work paid off as the experiment proved to be a success. The "stomach" could be used and it had many advantages over other hollow organs of the body. Not only was it technically feasible, but it also had strong muscle contraction and produced a good urine flow. There was no adverse effect on the dog receiving the operation, and its mildly acidic urine effectively counteracted bacterial growth.

I went on to perform the procedure on patients whose bladders had been removed entirely for the treatment of cancer.

It was a global first

It was such a success that the procedure was subsequently used to enlarge bladders which had contracted to the size of a

"thimble" due to tuberculosis of the urinary system – a common condition in the 60's and 70's. The procedure is now commonly known as "augmentation gastro cystoplasty".

Today, while tuberculosis of the bladder is rare, long-term ketamine addiction produces the same complications and would benefit from augmentation gastro cystoplasty.

Academic surgery is an honourable act. You develop a new and better surgical procedure but will never try to get a patent. On the contrary, you want as many people as possible to benefit from your innovation. If your work has true scientific value, you can write it up and the paper will be admitted for publication in important medical journals and you will get honourable mention by prestigious medical organizations.

The work on gastrocystoplasty was considered a breakthrough both in technology and in scientific research, and I was named a Hunterian Professor of the Royal College of Surgeons of England. What it entailed was that I had to fly to London to deliver a professorial lecture.

It was a great honour and an eye-opener. On the big day, I was led into the Edward Lumley Hall of the Royal College of Surgeons of England in Lincoln's Inn Field in Holborn, London, by the three "wise men" in full academic regalia – the President of the College, the Senior Vice President and the Registrar. Later, they sat straight-faced in the front row while I delivered the lecture. When the event was over, the trio led me into the President's Chamber where I was offered a congratulatory sherry

and a cheque in the amount of one guinea.

Nevertheless, I take pride in being the third person from Hong Kong, the first Hong Kong-born Chinese and the first Hong Kong University graduate to be so honoured.

Ultra-major surgery may lead to transient kidney failure. Before the kidneys start working again, the doctor has to keep the patient alive by artificially removing the "toxic waste products" of metabolism using an artificial kidney – a process called dialysis. In 1963, with a donation from the Rotary Club, an artificial kidney was installed in the surgical department of Queen Mary Hospital, and I became the first person to establish and take charge of a dialysis unit in Hong Kong.

The unit subsequently expanded to provide total replacement therapy – chronic dialysis for chronic renal failures, i.e. patients without functioning kidneys, with Professor Richard Yu (余宇康).

The role of doctors in society is to save lives by providing the best possible medical treatment, yet the role I had to play was more like God when I was given the charge of the dialysis unit. Once a patient had terminal kidney failure and was accepted for dialysis, he would need permanent dialysis from a machine 2-3 times a week. Such intensive use of the machine meant that it could only benefit a limited number of patients.

The question was who should get the benefit. It was a tough call to make. Imagine a situation where there were two patients suffering from kidney failure and you could only admit one of them. To admit a patient was to give him a "kiss of life", and to